



AFTER STROKE –LEARNING HOW TO LIVE WITH A DISABILITY

A patient guidance booklet

Leena Niemi

Elisa Poutiainen

Bachelor's thesis
October 2013
Degree Programme in Nursing
Option of Medical-Surgical
Nursing

ABSTRACT

Tampereen ammattikorkeakoulu
Tampere University of Applied Sciences
Degree Programme in Nursing
Option of Medical-Surgical Nursing

NIEMI, LEENA & POUTIAINEN, ELISA:
After Stroke – Learning How to Live with a Disability

Bachelor's thesis 34 pages, appendices 2 pages
October 2013

The purpose of this Bachelor's thesis was to produce a patient guidance booklet in English for foreign patients who suffer from cerebrovascular disorders. The booklet included general information about stroke and how to live with a disability. The family's role was also taken into account.

This thesis was carried out as a functional thesis. It was based on researched information. Literature was gathered from reliable sources, such as CINAHL, Pubmed and books related to the topic. The results from three expert interviews corroborated the information gathered from different sources. This thesis' emphasis was on multiculturalism and cerebrovascular disorders, especially focusing on rehabilitation and discharge process.

The fact that there were no existing studies concerning foreign stroke patients in Finland makes this thesis significant and it is beneficial for multicultural stroke patients. Further studies should be conducted to find out the needs of a foreign patient.

Keywords: stroke, rehabilitation, patient, nursing care, multiculturalism.

TIIVISTELMÄ

Tampereen ammattikorkeakoulu
Tampere University of Applied Sciences
Degree programme in Nursing
Medical-Surgical

NIEMI, LEENA & POUTIAINEN, ELISA:
Aivoverenkiertohäiriön jälkeen -Kuinka elää vamman kanssa

Bachelor's thesis 34 pages, appendices 2 pages
Lokakuu 2013

Opinnäytetyön tarkoituksena oli tuottaa englanninkielinen potilasohje ulkomaalaisille aivoverenkiertohäiriöpotilaille. Potilasohje sisältää yleistä tietoa aivoverenkiertohäiriöistä, sekä kuinka tulla toimeen aivoverenkiertohäiriön aiheuttaman vamman kanssa. Perheen rooli kuntoutumisprosessissa on myös otettu huomioon.

Toiminnallisen opinnäytetyön sisältö perustuu tutkittuun tietoon. Kirjallisuus opinnäytetyöhön on kerätty luotettavista lähteistä, kuten CINAHL, Pubmed ja aiheeseen liittyvästä kirjallisuudesta. Kolme ammattilaisten konsultaatiota vahvistivat aiheeseen liittyvät tutkimustiedot. Opinnäytetyön keskeisimmät käsitteet ovat monikulttuurisuus, aivoverenkiertohäiriöt, erityisesti keskittyen kuntoutukseen sekä kotiutumiseen.

Koska Suomessa ei ole tehty tutkimuksia koskien ulkomaalaisia potilaita, jotka ovat sairastaneet aivoverenkiertohäiriön, on tämä opinnäytetyö tärkeä ja hyödyllinen ulkomaalaisille aivoverenkiertohäiriöpotilaille. Lisätutkimusta aiheesta kuitenkin kaivattaisiin.

Asiasanat: aivoinfarkti, kuntoutus, potilas, hoitotyö, monikulttuurisuus

VOCABULARY AND ABBREVIATIONS

Aneurysm = A weakened section in the artery due to atherosclerosis or innate weakening. These sections may pouch out and rupture causing a hemorrhagic stroke.

Arterial dissection = A sudden rupture of the inner layer of a vein. The blood flows to the outer layers of the vein. The blood which has accumulated inside the layers may cause a stroke by disturbing the blood flow.

CVD = cerebrovascular disorder.

Dysphagia = Difficulties to swallow.

Dysphasia = Difficulties to understand, comprehend and form spoken and/or written language.

Embolus = A blood clot which has travelled from its original place in the circulation and plugged an artery or a vein.

Hemiparalysis = Paralysis of the left or right side of the body.

ICH = Intracranial hemorrhage. Bleeding in the brain, where the bleeding has occurred to the intracranial space.

Multidisciplinary team (MDT) = Health care professionals involved in the rehabilitation and care.

Normothermia = A condition of normal human body temperature.

Paralysis = Stagnation of motor neuron function due to a stroke, causing weakening of the muscle tone.

SAH = Subarachnoid hemorrhage. Bleeding has occurred to the subarachnoid space.

Thrombosis = A blood clot has plugged an artery.

TAMK = Tampere University of Applied Sciences

TAUH = Tampere University Hospital

CONTENTS

1	INTRODUCTION	6
2	PURPOSE, OBJECTIVES AND TASKS.....	7
3	CEREBROVASCULAR DISORDERS	8
3.1	Stroke	8
3.2	Cerebral hemorrhage.....	9
3.2.1.	Intracranial hemorrhage (ICH)	9
3.2.2.	Subarachnoid hemorrhage (SAH).....	9
4	TREATMENT	10
4.1	Diagnosis	10
4.2	Thrombolytic treatment	10
5	REHABILITATION	12
5.1	Involving the patient in rehabilitation.....	12
5.2	Mobilizing.....	13
5.3	Positioning	13
5.4	Nutrition.....	14
5.5	Family's role	15
5.6	Sexuality	16
6	DISCHARGE	17
6.1	Discharge planning	17
6.2	Nurse's role.....	18
6.3	Educational needs of the patient	18
6.4	Home.....	19
7	MULTICULTURALISM	21
7.1	Multicultural patients	21
7.2	Multicultural competence in health care.....	21
7.3	Use of an interpreter	22
7.4	Concept of time.....	23
7.5	Non-verbal communication	23
7.6	Bilingual patients	24
8	METHODOLOGY	25
9	DISCUSSION	27
10	CONCLUSION	29
	APPENDICES	33
	Appendix 1. Booklet.....	33

1 INTRODUCTION

Stroke is a vast life changing event and cause of disability. As the population ages, the number of new stroke incidents increases. The average age for a stroke patient is over 75 years of age. In Finland stroke is the fourth most common cause of death following coronary artery disease, cancer and dementia. Globally it is listed as the second most common cause of death. (Current Care Guidelines 2011.)

After stroke the patient's life will change significantly. Though the patient is in the middle of a life changing situation, the whole family will be affected as well. The roles in the family may change and new challenges in the daily activities may emerge. (Powell 2005, 50.) This thesis and booklet provide a tool for these foreign patients and their families. The goal is to encourage the whole family to support the patient and to encourage the patient to continue his or her life with the disability and learn how to live with it.

As requested by our working life connection, Hatanpään puistosairaala ward V1, the thesis explores stroke in Finland from the perspective of a multicultural patient, focusing especially in the rehabilitation stage and discharge, after a rehabilitation period. Questions and new needs will arise from the patients' daily activities after a hospital period. They may need assistive devices, physical therapy and other health care services more than before. Also self-care becomes vital. Producing a patient guidance booklet was also requested by the working life connection. The booklet focuses on the importance of self-care, providing information about stroke and important contact information.

2 PURPOSE, OBJECTIVES AND TASKS

The purpose of our functional thesis was to produce a patient guidance booklet for foreign patients who suffer from cerebrovascular disorders (CVD). The booklet could also be used as a tool by nurses who work with these patients. The objective of our thesis was to provide information to patients with CVD about their illness.

In the thesis the following questions will be answered.

- How does the cerebrovascular disorder change one's life?
- How to include the family in the rehabilitation process?
- How to implement rehabilitative nursing care?

3 CEREBROVASCULAR DISORDERS

3.1 Stroke

Commonly stroke is described as interruption of blood supply to the brain (Kerr 2012, 35-36.) There are two types of stroke: thrombosis or embolus, meaning that a blood clot has plugged an artery, and hemorrhagic stroke which means that a blood vessel has ruptured and blood has accumulated in the brain tissue causing pressure to the surrounding tissues (Maze 2008, 36-45).

Age seems to be the greatest risk factor along with gender. Men over the age of 75 are in greater risk of stroke than women of the same age. According to Finnish Current Care Guidelines (2011), heredity and ethnic features have also been suggested as factors increasing the risk of a stroke. (Current Care Guidelines 2011.)

In addition to advanced age, genetic features such as male gender, and ethnic background, have been seen as risk increasing factors, the risk is also increased among people who suffer from high blood pressure, high cholesterol levels, diabetes, obesity and smokers (Honkanen, Ilvesmäki, Jokelainen, Kari, Kauppinen, Knuutila, Peltomaa & Widenius 2006, 80-82; Maze 2008, 36-45).

Usually the symptoms start rapidly and they include dysphasia, dysphagia, confusion, headache, problems with walking and vision, and paralysis (Honkanen et al. 2006, 80-82). Arterial dissection seems to be a reason behind stroke for younger patients. Also a growing number of drug abusers are in higher risk of a stroke. (Roine 2009.)

The diagnosis is based on the symptoms and computed tomography (CT). The base for good nursing care and rehabilitation is to support the patient to maintain the daily activities and routines. (Honkanen et al. 2006, 80-82.)

3.2 Cerebral hemorrhage

Cerebral hemorrhage is divided into two different groups, according to the place where the hemorrhage has occurred (Honkanen et al. 2006, 82-83). Yearly approximately 2000 patients are affected with cerebral hemorrhage. The incidence of cerebral hemorrhages has declined due to improved care of high blood pressure. In the acute phase of cerebral hemorrhage the mortality is higher than in brain infarct. (Roine 2013.)

3.2.1. Intracranial hemorrhage (ICH)

In cerebral hemorrhage the brain tissue becomes damaged because of the perforation in the brain artery (Tays 2012). As with stroke, the onset of symptoms is rapid and includes progressive hemi-paralysis, weakening of cognition, convulsions, vomiting, and headache. The most common reason for ICH is high blood pressure and in some cases brain tumor. The care process is the same as with stroke patients. (Honkanen et al. 2006, 82-83.)

3.2.2. Subarachnoid hemorrhage (SAH)

The bleeding occurs to the subarachnoid place. According to Maze (2008, 36-45) patients usually describe the pain as the most severe they have ever experienced. As mentioned earlier, advanced age is one of the risk factors along with high blood pressure, alcohol abuse, use of oral contraceptive, as well as smoking and drug abuse. Especially the use of cocaine increases the risk of SAH. Also surgical procedures, angiography and lumbar puncture, may cause SAH. (Maze 2008, 36-45.)

Beside severe headache, other symptoms include neck pain, unconsciousness, vomiting, convulsions, and paralysis. The main reason for SAH is the innate eruption of the artery, which leads to aneurysms which may burst when doing physical exercise. The core of the treatment is to maintain vital functions, to prevent new hemorrhage by lowering blood pressure and immobilization, and to locate the place of hemorrhage with a CT scan. (Honkanen et al. 2006, 83-84.)

4 TREATMENT

In Pirkanmaa region, the patient's path to recovery starts from the moment a stroke is diagnosed. From the emergency care unit, Acuta, the patient is transferred to Stroke unit, STRO, where thrombolytic treatment is begun and primary care is provided. Usually patients stay at the Stroke unit from 1 to 3 days for acute care and are then admitted to the neurological ward at TAUH, their own health care centre, rehabilitation unit or home, if the symptoms have relieved enough and the patient's state is stable. (Tays 2013.)

The goal of the rapid onset of treatment is to prevent any further damage in the brain tissue and the progression of the stroke with anticoagulation treatment. Prevention of complications by securing breathing, maintaining normothermia, following blood glucose levels, and preventing aspiration by giving nothing by mouth, is an essential part of the care in the acute phase of stroke. Intravenous fluid therapy is started immediately. (Current Care Guidelines 2011.)

4.1 Diagnosis

Computed tomography, referred in text as CT scan, is the most informative tool to detect the cause of stroke (Frizzell 2005, 421-440; Current Care Guidelines 2011). Unfortunately some infarcts and ischemia are not visible in the CT until 24-48 hours from the onset of symptoms (Frizzell 2005, 421-440).

4.2 Thrombolytic treatment

Thrombolytic treatment is an effective treatment for stroke patients, but it does not suit everyone. The possibility for thrombolytic treatment is carefully estimated with every patient. It is important that a person suffering from symptoms of CVD is admitted to a hospital as soon as possible. Thrombolytic treatment is given intravenously and it needs to be started within 4 hours after the symptoms have started. Before the treatment can be

started, a CT scan needs to be taken. CT is taken for detecting any contraindications there can be, such as cerebral hemorrhage or a large brain infarct which has a risk for bleeding. (Tays 2011.)

Thrombolytic treatment is given intravenously and the infusion lasts for an hour. The medicine used is Alteplase, which dissolves the blood clots. During the treatment, the patient needs to be in bed rest and he/she is monitored carefully. Sometimes thrombolytic treatment does not have the desired effect and the clot does not dissolve. If that happens, a procedure to open the vein can be done. Thrombolytic treatment does not prevent a new blood clot from forming. (Tays 2011.)

According to Tays guidelines (2011), after 24 hours from the thrombolytic treatment a medication can be started that reduces the risk of forming new blood clots. It is important to prevent the recurrence of the disease by understanding the risks and treating them. (Tays 2011).

5 REHABILITATION

According to Current Care Guidelines (2011), approximately three months after a stroke, 50-70% of patients have recovered well enough to manage their daily chores independently. 15–30% of stroke patients are permanently disabled and approximately 20% cannot cope at home and are taken care of in a facility. Severity of the stroke affects the outcome of the recovery process. (Current care guidelines 2011.)

When a stroke happens, it causes nerve tissue damage which cannot be repaired. Nerve cells of the central nervous system cannot regenerate, but they can create new connections and their function can be reorganized. Best results can be achieved by starting rehabilitation as soon as possible. Consistent rehabilitation aims to fix functional deficits and reduce the damage the stroke has caused. (Salmenperä, Tuli & Virta 2002, 54.)

5.1 Involving the patient in rehabilitation

According to Peoples, Satink and Steultjens (2011, 163-171) stroke patients have experienced that the most important thing concerning rehabilitation and coping with everyday life was to receive help when needed and especially practical help in every day routines: "...so that handicap and daily living could be combined." During their hospital stay, patients experienced hospital environment and ward's daily routines uncomfortable and inflexible (Peoples et al. 2011, 163-171).

Good, quality information offered throughout the rehabilitation stage is a coping tool for patients, to get along with the illness. With proper information and realistic goals for rehabilitation and the progress they have achieved, it is easier for the patients to accept the illness. Lack of information may lead to passiveness among the patients. (Peoples et al. 2011, 163-171.) The knowledge also provides the patients with the feeling of control over their own life and empowerment which promotes recovery. Also remaining in contact to the patient's family has a positive effect on empowerment. (Peoples et al. 2011, 163-171.)

5.2 Mobilizing

The stroke patient's ability to produce movement and receive impulses from their own body or environment can be disrupted. The ability to control movement and positioning requires the functioning of nerve system, bones, muscles and joints. (Tays 2012.) Patient guidance needs to be consistent no matter who is giving the guidance (Salmenperä et al. 2002, 56-57).

The nursing care staff evaluates the patient's capacity to control his/her body and how safely he/she is able to move, so that the rehabilitation can be started as early as possible. The staff should develop their ability to evaluate problems that patients face, with their ability to function and move. Nurses should use the help of physical therapists to resolve these problems. (Salmenperä et al. 2002, 56-57.)

The nature of the cerebrovascular disorder needs to be known before mobilizing the patient. The patient also needs to be in solid condition and his/her vitals need to be stable. If the infarct or hemorrhage is wide, mobilizing the patient in the first 24 hours is rarely done. It is important for the whole staff to know how the patient is mobilized and what the restrictions are. (Salmenperä et al. 2002, 56-57.)

5.3 Positioning

Salmenperä et al. (2002) state that changing the position stimulates the patient. The patient can be guided more versatile in different situations when they are not in bed, and are sitting for example in a wheel chair. When a patient is sitting in a wheel chair, he/she has a better and more supportive position. Especially in eating situations, it is better that the patient sits. (Salmenperä et al. 2002, 57-58.)

Taking care of good positioning begins immediately after the patient arrives at the hospital. Well executed positioning improves breathing and circulation. Side positions are recommended. When lying on his/her side the patient cannot aspirate saliva, which prevents the patient from getting aspiration pneumonia. The patient is advised to change the position as often as he/she wants or in short regular periods, because it prevents the

formation of pressure wounds. Skin condition needs to be checked regularly and the patient's position should be changed every two hours at night too. Decubitus mattresses can also be used for pressure ulcer prevention. For safety, the patient often needs to have the sides of the bed raised. (Salmenperä et al. 2002, 57-58.)

Moving practices are done in different stages, starting from the less demanding functions to more demanding. Patient's development is constantly followed.

1. turning and mobilizing in bed
2. sitting up
3. controlling your sitting
4. shifting to wheel chair and back
5. standing up
6. controlling your standing
7. walking

Before discharge, the patient will also practice walking up the stairs, sitting on the floor, and getting up from the floor with a physical therapist. (Salmenperä et al. 2002, 57-58.)

5.4 Nutrition

Dysphagia, meaning a problem with swallowing, is a common problem with patients suffering from CVD. Depending on where in the brain the injured part is, dysphagia can be a short-term or a long-term problem. Dysphagia can have different effects. The patient may have problems with chewing the food properly and swallowing it or the food can stay in the mouth or throat after swallowing. Food and drinks can also go to the trachea instead of esophagus and cause aspiration. (Salmenperä et al. 2002, 58-60.)

According to Tays (2012) guidelines, per oral nutrition is started as soon as possible. The patient's ability to eat and swallow is tested at the ward. If the patient cannot eat or swallow properly, his/her nutritional needs are taken care of, with parenteral or enteral feeding. Dysphagia and other problems with eating affect the texture of food given. A speech therapist will determine in what form the given food can be. Also drinks can be thickened if needed. (Tays 2012.)

5.5 Family's role

According to Powell (2005, 50), the patient's family is in a key role with the care staff in the rehabilitation phase. The family should encourage and motivate the patient. The family's active participation in the rehabilitation process has yielded positive results and faster recovery time. (Powell 2005, 50.)

For caregivers and stroke survivors there are peer-groups that offer recreational activities and gatherings to people who are in the same life situation. The caregiver should also take care of him or herself. He or she should visit friends and relatives, maintain physical health and exercise, and make time for hobbies and interests. (Hutton 2005, 164.)

Lynch, Butt, Heinemann, Victorson, Nowinski, Perez and Cella (2008) have studied changes in stroke survivors' social connections and relationships. The study focused on the role changes in the family, independence, and social support. The issues related to those topics varied with stroke patients and their caregivers. (Lynch et al. 2008, 518-523.)

Communication problems were highlighted by patients in the study. They felt that speech problems affected their self-esteem and self-confidence. (Lynch et al. 2008, 518-523.) Also Hutton (2005, 164) states that married couples should learn to communicate effectively. Roles among the family may change due to stroke. Usually the one who is not affected with stroke becomes a caregiver. The changes will become clearer when time has passed and the new daily routines have settled. The spouse should give the stroke survivor a say in the family's matters, give responsibility and charge as much as the person can handle. If there are little children in the family, they may have questions about the new situation. Their questions should be answered honestly and adults should help them understand the new situation. (Hutton 2005, 164.)

Quality of life is mainly affected by social relationships. Because the majority of stroke survivors are dependent on others, their social networks become more important than before. (Lynch et al. 2008, 518-523.)

In some cases the family members are not able or willing to take care of a stroke survivor. In order to ensure safety of residence for a stroke patient, it needs to be assessed if the caregiver is able to provide adequate care to the patient. An elderly spouse may not be able to handle all the physical and emotional stress that the task of a caregiver brings. Also adult children may be unwilling or unable to adjust to the parent's new life situation and be incapable to assist in daily activities in a way that the situation requires. (U.S. Department of Health and Human Services. Post-Stroke Rehabilitation 1995.)

5.6 Sexuality

Hutton (2005, 159) encourages couples to talk about sex. Stroke may have damaged some stimulus or the other side of the body. The patient should explain exactly what he or she wants and which part(s) of the body have been affected the most. Therefore the partner should stimulate the side that is not affected. In time, for example visual stimulation may improve. Partners should talk about what arouses them, which positions are suitable and about touching and relaxation. In case of erectile dysfunction, a physician should be consulted about taking sexually arousing medication. Contraception should not be forgotten. Stroke does not exclude the possibility of pregnancy or sexually transmitted diseases. If the patient has any questions or problems related to sexuality, they may turn to a sexual therapist for help and tips. (Hutton 2005, 159.)

6 DISCHARGE

For some stroke patients, rehabilitation in home environment reduces long term dependency and also admission to institutional care. Discharge should be co-ordinated and follow up appointments should be well organized after discharge. Pessah-Rasmussen and Wendel (2009, 482-488) claim that motivation and compliance to care increase among those patients who receive rehabilitation services in a home setting. Also the goals for rehabilitation are easier to set in a familiar environment, where the patient has to go through everyday activities (Pessah-Rasmussen & Wendel 2009, 482-488). Langhorn and Widen-Holmqvist (2006, 103-108) also state that patients felt that after they were discharged from hospital, they were more into taking responsibility of setting individual goals for rehabilitation than those who were in hospital rehabilitation. Also the identification of problems and areas to concentrate on were clearer in home environment for therapists working with the client (Langhorn & Widen-Holmqvist 2006, 103-108).

6.1 Discharge planning

Before the discharge, the patients have no idea how their life at home has changed after stroke and what will happen after the discharge from hospital. Therefore involvement in planning relieves anxiety and distress. In order to include the patient in care planning and discharge planning, they must have adequate knowledge concerning treatment, course of illness, diagnosis, goals of rehabilitation, and of course patients have to be in such a mental state that they acknowledges their condition. (Almborg, Ulander, Thulin & Berg 2007, 857-865.)

According to Almborg et al. (2007, 857-865), the patients and professionals may have different points of view when it comes to arranging their post stroke life situation. When the health care team prepares goals and actions to increase the function ability, the patients focus on pre-stroke social status and facing different life situations. Because the patient is in need of services and care, he or she should then be allowed to participate in the discharge planning. (Almborg et al. 2007, 857-865.)

6.2 Nurse's role

A nurse is in a key role helping the patient come in terms with stroke. Burton (2000, 174-181) and Peoples et al. (2011, 163-171) state that the nurse's actions and attitude affect how the patients react to their illness. For instance, if the nurse just does things for the patient, the patient's participation in care and rehabilitation may become passive. (Burton 2000, 174-181.) Empowering the patient in care involves keeping up the positive atmosphere, paying attention to the patient's own priorities, involving the patient in decision making, and providing individualized information and emotional support. The nurse must evaluate the patient's capability in the decision making process as well as how much empowering the patient can take. (Burton 2000, 174-181; Peoples 2011, 163-171.)

The nurse's role has an important input in the multidisciplinary team (MDT) of health care professionals involved in the rehabilitation and care. When planning goals for the rehabilitation, the participants of MDT need important information about patients' daily activities, which a nurse has the most experience of. Nurses can affect the therapy methods and interventions used in the rehabilitation, because of plenty of interaction with the patient, by telling about activities of living, coping and well-being of the patient. Also the interaction affects the outcome of rehabilitation as well as the quality. (Burton 2000, 174-181.)

6.3 Educational needs of the patient

Yonatu & Kitchie (2012, E1-E9) have studied education for stroke patients who were hospitalized. Two weeks after discharge from hospital the patients were asked to list the most important aspects of patient education they valued. According to the study, education about medication treatment and medical knowledge was pointed out as the most important need for information. (Yonatu & Kitchie 2012, E1-E9.) Also Matthews (2009, 7-11) suggests that medication education for a patient who is going home should be adequate. Well executed medication education reduces mortality and morbidity and readmission to hospital. Before discharging the patient, the care staff should determine

if the patient is able to carry out medication administration in a home setting and if he or she is able to receive information given to him or her. The family members' abilities to learn, e.g. giving injections safely and handle the medication treatment accordingly, should also be assessed. (Matthews 2009, 7-11; Yonatu & Kitchie 2012, E1-E9.)

In general, patients were not satisfied with their patient education, feeling they were not given enough information regarding their condition. Additionally, the study states that adequate patient education prevents further complications and illnesses after stroke. The patients stated that they needed different types of information in different stages of rehabilitation, knowledge about controlling risk factors, and answers to their questions. (Yonatu & Kitchie 2012, E1-E9.)

6.4 Home

Erikson, Park and Tham (2010, 68-77) have stated that places affect the stroke patients' motivation to recovery. The study followed patients one year after stroke and as a result, the need to be in familiar places, for example home or work, was the factor that motivated them during the active rehabilitation stage. As a chronic condition, stroke may have caused life limiting features, such as loss of memory, cognitive disorders or physical impairment. Therefore, the home they were accustomed to, may be restricting and not suitable for the patient's needs in his/her current condition. In a rehabilitation clinic, occupational therapists are involved in the discharge process as well as in the rehabilitation. Before settling back home, the patient has a few practice home stays. The occupational therapists plan the necessary modifications and home aids along with the patient. (Erikson et al. 2010, 68-77.)

Though for many patients home is seen as the motivating factor, Erikson et al. (2010) mention that for some, the idea of going back home is frightening and uncomfortable. The rehabilitation clinics provide a safe environment with the professional staff always ready to help, whereas at home the patient may feel that he or she is on his or her own. Visits at home may help bring inspiration to the patient on what to involve in the rehabilitation, what the skills he or she is able to relearn or needs to learn are, and what the activities that need to be rehearsed are. (Erikson et al. 2010, 68-77.)

A home visit to identify the safety hazards should be done before the actual discharge. During the visit, the patient's daily routines, services needed, and alterations are mapped. If a visit is not possible, this ought to be done by discussing with the patient about his or her home environment. (Meyer & Derr 2007, 109-129.)

To ensure safe home environment for the stroke patient, all the unnecessary furniture ought to be removed. Also the furniture should be placed so that there is enough room to move, especially if the patient needs any walking aids, for example a wheelchair or a walking stick. If the patient needs to lean on furniture, ensuring that they stay on their places is essential. The alterations should be done minding the patient's safety and making the daily activities as easy as possible. (Meyer & Derr 2007, 109-129.)

7 MULTICULTURALISM

Multiculturalism describes culturally diverse people or groups of people, living in the same time and place. Multicultural care, as an aspect of health care, refers to work carried out among different cultures or it may mean a work community, where the workers and clients are from various cultures and represent different ethnicities. The goal of multicultural care is to take the patient's culture into consideration, in correlation to health and enhancing well-being. (Abdelhamid et al. 2009, 18-19.)

7.1 Multicultural patients

In a study by The National Advisory Board on Social Welfare and Health Care Ethics (2004, 29), it is mentioned that immigrants who participated in the study about health care services in Finland feel they have received good quality care, although they criticize the care personnel's attitude towards them and how they were treated. The most unsatisfied patients were Russians and immigrants born after 1950's. The most common problems were difficulties understanding the Finnish health care organization, a new hospital culture, and language difficulties. From the nurses' point of view, the problems of organizing good quality care were understanding the patient's culture and background, taking into account their individual needs, and workers' and immigrants' negative attitudes and prejudices. (Etene 2004, 29.)

7.2 Multicultural competence in health care

When meeting a multicultural patient, the outer features such as manners, clothes, language, age, skin colour and gender catch the nurse's eye. In order to provide multiculturally competent care, the nurse should be focusing on invisible features: identity, ideology, expectations, beliefs and the importance of family and traditions of patient's culture. (Abdelhamid, Juntunen & Koskinen 2009, 75-77.) According to Abdelhamid et al. (2009, 35), a key factor in the nurse-patient relationship in a multicultural environment is that a nurse understands the patient's point of view although the nurse would not oth-

erwise approve of it. Battle (2012, 57) notifies that culturally competent care is a continuous process of understanding a different culture. Interaction between health care professional and a patient can be influenced by different culture, age, gender, socioeconomic status, ethnic group and religion. Knowledge and resources are needed in order to gain competence in multicultural care. (Battle 2012, 57.)

Comprehension of foreign matters does not come naturally, because for human beings it is more typical to feel scared and threatened when meeting someone from a foreign culture. The nurse's own feelings and background should not interfere when meeting a person representing another culture. (Abdelhamid et al. 2009, 32-33.) Culturally competent care increases the patient's participation and compliance in care and improves the commitment to follow-up care (Battle 2012, 58-57).

Along with the rapidly increasing number of immigrants, new challenges have emerged to the Finnish health care system. Immigrant patients may have a history of refugeeism, social exclusion, marginalization, and feelings of being an outsider. (Abdelhamid et al. 2009, 25.) In addition, one of today's trends is making life changing decisions: eating healthy, exercising regularly and quitting smoking – these decisions are increasing people's life expectancy. The longer the population lives, the more people will be reaching an age where the risk of cardiovascular diseases and neurological disorders is increased, so the older population will need more services addressed individually for their needs. (Battle 2012, 57-59.)

7.3 Use of an interpreter

Suzuki and Ponterotto (2008, 233-234) highlight the use of a trained interpreter. With the help of an interpreter, quality care can be provided to the patient. The interpreter should be prepared for the settings, so he or she would know what is going on, in order for the interpretation to provide efficient information. First the language of the patient should be assessed and gain a total certainty of that. Dialect, gender, age, ethnic group, religion and socioeconomic status are essential in order to result in a good match and good interpretation. (Suzuki & Ponterotto 2008, 233-234.)

7.4 Concept of time

Translating time, if a different calendar is used in the patient's original country, may cause errors and uncertainty of date of birth and important events. There are also different ways of talking about time, for example in English and Mandarin. In addition, if a refugee or immigrant has encountered a serious trauma, he/she might not remember certain dates or time from that period of his/her life. Some may talk about a certain time of a day and use for example the word morning and not the specific hour, and this may mean that the patient comes late to his/her appointment. (Suzuki & Ponterotto 2008, 173-174.)

Battle (2012, 59-60) also states that orientation to time varies from culture to culture. The goals for treatment should be then set according to cultural view of time. Some may focus on the future and value long term goals and some value the past and present, therefore they relate to short term goals. Western cultures tend to focus on the future and in cultures where ancestors and the elderly are valued, the focus is on the past and present. (Battle 2012, 59-60.)

7.5 Non-verbal communication

When encountering a patient from another culture, a nurse should be aware of variations in gestures and body language. When communicating with the patient, a nurse should be sure that he or she has understood the patient's gesture or expression in the right context, because different cultures have their own expressions and meanings for them. Sounds, movements, gestures, and expressions may vary vastly from culture to culture. In Western countries, for example, eye contact is seen as a sign of honesty, but in some African cultures maintaining direct eye contact is a sign of disrespect and it is considered rude. In China facial expressions of emotions are suppressed and not encouraged to be shown. (Suzuki & Ponterotto 2008, 59.)

7.6 Bilingual patients

With bilingual patients, it should be assessed if the therapy and rehabilitation should be arranged in the patient's native language, or in the second language or both. The problem with bilingual patients is that the health care professional encountering the patient must have fluent language skills of the patient's language, because he or she needs to explain the disorder, care, therapy and rehabilitation to the patient and family members and make sure that they have understood what is going on. (Menn 1995, 133-135.)

8 METHODOLOGY

The objective of a functional thesis is to create practical guidelines, directions and activity organizing and rationalizing skills. Depending on the specific field, the outcome can be a booklet, portfolio, book, cd, webpage or an event or exhibition. (Vilkka & Airaksinen 2003, 9.) The thesis should be originated from the working life and based on researched information. It should also show that the author has sufficient knowledge and skills of his or her own field. (Vilkka & Airaksinen 2003,10.)

Falvo (2010) and Hyvärinen (2005) both highlight that patient guidance ought to be visually appealing and easy to read. Logical structure and consistent use of commonly understood terms make a patient guidance booklet more appealing to the reader. (Falvo 2010, 422; Hyvärinen 2005). Abstract language and words should be avoided. In the process of writing a patient guidance booklet, the target audience should be taken into consideration, as well as what is the level of understanding and whether the patient is able to read. In addition, the writer should pay attention to the print and typing. Short sentences should be used and examples targeted to the patient. For example, instead of writing “When a patient is showering...” the instructions should be written directly to the patient: “When you shower...”. (Falvo 2010, 422.) In addition, Hyvärinen (2005, 1769-73) underlines that the instructions given in the booklet need to be rationalized. Rationalization should be in such a form that the patient realizes the benefit of acting as instructed (Hyvärinen 2005, 1769-73). Hyvärinen (2005, 1769-73) also recommends to keep the guidance booklet short, because very detailed information may be confusing for some. If the writer wants, he or she may add a reference list for more readings, for those who want to know more about the subject. (Hyvärinen 2005, 1769-73.)

The content of the booklet is based on the theoretical framework of the thesis. Expert interviews of specialists working with stroke patients have also affected the content of the booklet. In addition we gained information about what happens after discharge and what services the patients may need at home. The information from the expert interviews coincides with the research results we found. The booklet tells briefly about the cerebrovascular disorder and focuses more on the self-care and on encouraging the family to support the patient. There is also useful information for the family members. Con-

tact information for different health care services and interpretation services is included with short descriptions. Phone numbers, webpages and addresses are listed accordingly.

9 DISCUSSION

The topic for this thesis was brought up by Hatanpään puistosairaala, ward V1. At the beginning of the process we met with the personnel from the V1 ward. In the meeting we talked about what to include in the thesis and the booklet.

Literature for the thesis was gathered via reliable sources such as CINAHL, Pubmed and books related to the topic. The search words varied from subtopic to subtopic, though the word ‘stroke’ was used in every search to limit the articles to the specific topic. Besides stroke, we focused on rehabilitation and recovery, and subsequently, they were the second most used search words after ‘stroke’.

Other than articles and books related to the topic, we conducted three expert interviews. Two of them were recorded and one interview was written down, due to the changing circumstances during the interview. First we contacted a person in Finnish Brain Association and the office of a brain association of Pirkanmaa region (Pirkanmaan avh-yhdistys) via e-mail. The brain association of Pirkanmaa region has not answered to our inquiry to date and the person we contacted in Finnish Brain Association sent us contact information of two rehabilitation instructors in Tampere area to interview. The interviews were recommended by the working life connection and the places for material search were conducted by the recommendations and preferences of the Tampere University of Applied Sciences (TAMK).

Vilkka & Airaksinen (2003, 76) state that the references for a functional thesis should be applicable for the purpose. The quality of the references is more important than the quantity. As Vilkka & Airaksinen (2003, 73) recommend, the references for the thesis were limited only to the newest material available. Only a few sources date further than the year 2000. The use of articles, books and expert interviews as references from databases is recommended by Vilkka & Airaksinen (2003, 76-77). The material is gathered from Finnish and various culturally diverse sources, in order to gain varied information on the subject. With no existing Finnish data at the moment, the authors of the thesis had to apply relevant data from other cultures to the theoretical framework.

The data were analyzed as obtained, with no misinterpretations (Taylor, Kermode & Roberts 2006, 18). In the thesis we provide truthful information about cerebrovascular disorder, health and self-care (Sairaanhoitajaliitto 2013). The theoretical framework is based on researched information. (Polit & Beck 2012, 169.)

A limitation of our thesis was that there are no existing studies related to multiculturalism and stroke in Finland. Even though there were no previous Finnish studies about foreign stroke patients, we found reliable information from studies conducted abroad. We suggest that further studies should focus on the needs of foreign stroke patients who live in Finland. In the future, patients could be interviewed to gain deeper information about their needs.

10 CONCLUSION

The aim of the thesis was to produce a patient guidance booklet for multicultural stroke patients living in Finland. The thesis was commissioned by Hatanpään puistosairaala ward V1. The material was gathered via reliable databases, books and expert interviews. The material for the booklet came from the theoretical framework of the thesis. The authors of the thesis planned the layout of the booklet. The booklet is beneficial for patients with cerebrovascular disorders.

REFERENCES

- Abdelhamid, P, Juntunen, A. & Koskinen, L. 2009. Monikulttuurinen hoitotyö. WSOY-pro Oy.
- Ahava, S. Sairaanhoitaja. 2013. Haastattelu 19.4.2013. Haastattelijat Niemi, L & Poutiainen, E. Tampere.
- Almborg, A-H., Ulander, K., Thulin, A. & Berg, S. 2009. Patients' Perceptions of Their Participation in Discharge Planning After Acute Stroke. *Journal of Clinical Nursing*. 18 (6), 857-65. Read 19.5.2013.
- Battle, D.E. 2012. *Communication Disorders in Multicultural Populations*. Elsevier Health Sciences. Read: 11.3.2012.
- Burton, C.R. 2000. A Description of The Nursing Role in Stroke Rehabilitation. *Journal of Advanced Nursing*. 32: 174-181. Read 11.3.2013.
- Current care guidelines. 2011. Suomalaisen Lääkäriseuran Duodecimin ja Suomen Neurologinen Yhdistys ry:n asettama työryhmä. Read 10.3.2013. <http://www.kaypahoito.fi>
- Erikson, A., Park, M. & Tham, K. 2010 Place Integration Through Daily Activities 1 Year After Stroke. *Occupation, Participation and Health*. 30, (2). 2010. 68-77. Read 10.3.2013.
- Falvo, D. 2010. *Effective patient education: A Guide to Increased Adherence*. Jones & Bartlett Publishers.
- Frizzell, J. P. 2005. Acute Stroke – Pathophysiology, Diagnosis and Treatment. *AACN Clinical issues*. 16, (4). 421 - 440. Read 20.5.2013.
- Honkanen, E., Ilvesmäki, V., Jokaleinen, K., Kari, J., Kauppinen, R., Knuutila, A., Peltonmaa, R. & Widenius, T. 2006. *Sisätautien ytimessä*. Helsinki: Edita Publishing Oy.
- Hutton, C. 2005. *After A Stroke: 300 Tips for Making Life Easier*. Demos Medical Publishing.
- Hyvärinen, R. 2005. Millainen on toimiva potilasohje? *Duodecim*. 121: 1769-73.
- Kerr, P. 2012. Stroke Rehabilitation and Discharge Planning. *Nursing Standard* 27, 35-36. Read 11.2.2013.
- Langhorne, P. Widen-Holmqvist, L. 2006. Early Supported Discharge After Stroke. *Journal of Rehabilitation Medicine*. 39 (2). 103-108. Read 6.5.2013.
- Lynch, E.B., Butt, Z. Heinemann, A., Victroson, D., Nowinski, C.J., Perez, L. & Cella, D. 2008. A Quality Study of Quality of Life After Stroke: The Importance of Social Relationships. *Journal of Rehabilitation Medicine*. 40: 518–523. Read 21.5.2013.

Matthews, S. 2009. Interventions for Rehabilitation Post-stroke and the Contribution of The Nursing Staff. Journal of the Australasian Rehabilitation Nurse's Association. 12: 7-11. 11.5.2013.

Maze, L. N. 2008. Stroke – An all-out assault on the brain. LPN. 4 (3). 36-45. Read 11.5.2013.

Menn, L. 1995. Non-Fluent Aphasia in a Multilingual World. John Benjamins Publishing. Read: 11.3.2013.

Meyer, M.M. & Derr, P. 2007. The Comfort of Home for Stroke. A Guide for Caregivers. CareTrust Publications LLC.

Monikulttuurisuus Suomen terveydenhuollossa. Valtakunnallinen terveydenhuollon eettinen neuvottelukunta (ETENE), 17.8.2004, 5. kesäseminaari, Helsinki. Luettu 10.12.2012.

Peoples, H. Satink, T. & Steultjens, E. 2011. Stroke Survivors' Experiences of Rehabilitation: A Systematic Review of Qualitative Studies. Scandinavian Journal of Occupational Therapy. 18: 163-171.

Pessah-Rasmussen, H. & Wendel, K. 2009. Early Supported Discharge After Stroke and Continued Rehabilitation at Home Coordinated and Delivered by a Stroke Unit in an Urban Area. Journal of Rehabilitation Medicine; 41: 482–488. Read 8.5.2013.

Polit, D. & Beck, C. 2012. Nursing research. Generating and Assessing Evidence for Nursing Practice. 9th edition. Philadelphia: Lippincott Williams & Wilkins.

Powell, T. 2005. Pään Vammat. Helsinki: Edita.

Roine, R. O. 2009. Aivoinfarkti. Lääkärin käsikirja. Duodecim. Read 25.3.2013. www.terveysportti.fi

Roine, R.O. 2013. Aivoverenvuoto. Lääkärinkäsikirja. Duodecim. Read 20.11.2013. www.terveysportti.fi

Salmenperä, R., Tuli, S. & Virta, M. 2002. Neurologisen ja neurokirurgisen potilaan hoitotyö. Helsinki: Tammi.

Sandberg, T. Sairaanhoitaja. 2013. Haastattelu 29.5.2013. Haastattelijat Niemi, L & Poutiainen, E. Tampere.

Sjögren, R. Kuntoutusohjaaja. 2013. Haastattelu 19.4.2013. Haastattelijat Niemi, L & Poutiainen, E. Tampere.

Suzuki, L.A. Ponterotto, J.G. 2008. Handbook of Multicultural Assessment: Clinical, Psychological and Educational Applications. John Wiley & Sons.

Taylor, B., Kermode, S. & Roberts, C. 2006. Research In Nursing And Health Care: Evidence For Practice. Thomson. 3rd edition.

Tays 2012. Aivoverenkiertohäiriöpotilaan ohjaus. Aivoinfarktin liuotushoito. 3.6.2011. Read 16.5.2013. <http://www.pshp.fi/default.aspx?contentid=1468&contentlan=1>

Tays 2012. Aivoverenkiertohäiriöpotilaan ohjaus. Mikä on aivoverenkiertohäiriö. 3.6.2011. Read 19.5.2013. <http://www.pshp.fi/default.aspx?contentid=1468&contentlan=1>

Tays 2012. Aivoverenkiertohäiriöpotilaan ohjaus. Aivoverenkiertohäiriöt ja muutokset lihastoiminnoissa ja tuntoaistimuksissa. 26.11.2012. Read 19.5.2013. <http://www.pshp.fi/default.aspx?contentid=1468&contentlan=1>

Tays 2012. Aivoverenkiertohäiriöpotilaan ohjaus. Aivoverenkiertohäiriö ja nielemisvaikeus. 1.6.2011. Read 19.5.2013. <http://www.pshp.fi/default.aspx?contentid=1468&contentlan=1>

Tays. 2013. Aivoverenkiertohäiriöyksikkö. 4.4.2013. Read 10.3.2013. <http://www.tays.fi/default.aspx?contentid=3518&contentlan=1>

U.S. Department of Health and Human Services. 1995. Post-Stroke Rehabilitation. Public Health Services. Agency for Health Care Policy and Research. Rockville, Maryland.

Vilkka, H., Airaksinen, T. 2003. Toiminnallinen opinnäytetyö. Helsinki: Kustannusosakeyhtiö Tammi.

Yonatu, S-A. & Kitchie, S. 2012. The educational needs of newly diagnosed stroke patients. Journal of Neuroscience Nursing. 44 (5), E1-E9. Read 20.5.2013.

APPENDICES

Appendix 1. Booklet

Contact information

Aivoliitto
Information about stroke
www.aivoliitto.fi

AHT - contact person in Tampere
Jenni Toivonen tel. 040 801 8822

Emergency number in Finland:
112

Health services in Tampere area
Information and advice every day 7-22
Telephone: 05 10025

Immigrant Advice Centre
Multi-lingual information and guidance services
maahanmuuttajaneuvonta@tamperet.fi
Tel. 040 808 2526
Tel. 040 808 2527
Tuomiokirkonkatu 12
33100 Tampere

Pirkanmaa Interpretation Centre
Booking for interpreters:
Tel. 05 8657 7314,
Monday - Thursday 8 - 15.45, Friday 8 - 15.15

Kela
Provides social benefits such as sickness insurance, unemployment insurance and basic pension insurance.
Tel. 05 8657 0200

AFTER STROKE - learning how to live with a disability



Stroke is a life changing disease. You may have already noticed changes in your body and mind. Taking care of your health is now more important than before. In this booklet there is included information on how to take care of yourself and who to contact if you have questions.

What is a stroke?

A stroke is caused by an interruption of blood supply to the brain. There are two types of stroke. Thrombosis means that a blood clot has plugged an artery in your brain. Hemorrhagic stroke means that a blood vessel has ruptured and blood has accumulated in the brain tissue causing pressure to the surrounding tissues.

The symptoms start rapidly. If you suspect that you or your family member has had a stroke, call 112.

Symptoms of a stroke:

- Headache
- Neck pain
- Loss of muscle tone
- Vomiting
- Difficulties in speech
- Dizziness



References:

Aivoinferkti. Käypä hoito. 2011. Suomalaisen lääkäriseuran Duodecim ja Suomen neurologinen Yhdistys ry:n asettama työryhmä.

Niemi, L. & Poutinen, E. 2013. After stroke –Learning how to live with a disability. Degree Programme in Nursing. Tampere University of Applied Sciences. Bachelor's thesis.

Powell, T. 2005. Pään vammat. Helsinki. Edita.

Töys. 2012. Mikä on aivoverenkiertohäiriö. www.pshp.fi

Sexuality

You should talk to your partner about sex. Stroke may have damaged some stimulus or the other side of your body. Communicate with your partner about which parts of your body have been affected and what stimulates you the most.

In case of erectile dysfunction, you should talk to your doctor about taking sexual arousal medication. Protection should not be forgotten. Stroke does not exclude the possibility of pregnancy or sexually transmitted diseases. If you have any questions or problems related to sexuality, you may turn to a sexual therapist for help and tips.



Risk factors:

- High blood pressure
- Obesity
- Alcohol abuse
- Smoking
- Diabetes
- Cardiovascular diseases
- High cholesterol levels

By reducing these risk factors, you can prevent another cerebrovascular event from happening.

If you need more information on how to reduce these risk factors, contact your local doctor or a nurse.



Consequences of a stroke

After a stroke you may have some of these disabilities

- Neglect
- Difficulties to carry out movements (Apraxia)
- Difficulties to swallow (Dysphagia)
- Difficulties in speech (Aphasia)
- Memory problems
- Perceptual deficits
- Attention deficits
- Mood and personality changes

Rehabilitation at home

Rehabilitation is designed for your individual needs. Everyday activities are a great way to support your recovery process. In case of decreased ability to function, rehabilitation at home can be supported by different therapies.

When the rehabilitation process progresses, the need for therapy decreases. Then you have to take more responsibility of your own recovery. During a home visit, a therapist gives you advice on different exercises and moving.

Before discharge from hospital, a home visit is done to find out your needs for services and assistive devices. A AVH (cerebrovascular disorders) contact person helps you with these needs.

Family

The family should encourage and motivate the patient. The family's active participation in rehabilitation has a positive effect and it can promote faster recovery.

Roles in the family may change after a stroke. Usually the one who is not affected by the stroke becomes a caregiver. If there are little children in the family they may have questions about the new situation. Their questions should be answered honestly and the parents should help them understand the new situation.

The caregiver should also take care of him or herself. He or she should go and visit a friend or relative, maintain physical health and exercise and make time for hobbies and interests.

For family members, there are support groups that can be found via Aivollitto or local AVH association.

